Expedited Psychiatric Inpatient Admission
Referral Form to Request DMH Assistance at 96 hours

A T T E N T I O N: Please use this form to request DMH assistance for individuals without a plan at 96 hours into an Emergency Room visit

1. Are you an *INSURANCE CARRIER, *ESP or *ED?	
2. Name of referring Organization	
Provide senior leadership information at the referring entity below that DMH should contact:	
3. First Name	
4. Last Name	
5. Title of the person above	
6. Contact telephone number of the person above	
7. Contact Email Address of the person above	
Please provide member demographic Information below:	
8. First Name	
9. Last Name	
10. DOB (mm/dd/yyyy)	
11. Gender	
12. Is the member's ethnicity Hispanic or Latino? **YES or NO**	
13. What is the member's race?	
14. What is the member's ethnicity?	
15. Guardian/Custody	
16. Insurance Carrier	
17. Insurance Plan Type (Check all those that apply	
18. State agency involvement (List those that apply)	
Please provide boarding details below:	

19. Where is the Member boarding?	
20. Which ESP is involved (if applicable)?	
21. Date and Time of initial evaluation (mm/dd/yyyy) (Please use military format e.g. 2300 is 11PM)	
22. Date and Time of request for assistance to insurance carrier (mm/dd/yyyy) (Please use military format e.g. 2300 is 11PM)	
23. Diagnosis	
24. Secondary Diagnosis	
25. Identify the primary barrier to placement:	
26. Please describe "other" barriers here	
27. Provide presenting concerns & precipitating events (clinical formulation-if available) *SUMMARY ONLY*	
28. Please describe any services authorized by Carrier to support admission (e.g., 1:1, single room, enhanced medical supports etc...)	
29. Out of network facilities considered (if any)	
INPATIENT FACILITIES TO TARGET FOR DMH INTERVENTION	
Inpatient Facilities where senior leadership and/or CMO were contacted by insurance carrier to have follow-up discussions, doc-to-doc, etc...to advocate for admission and escalation results	
---------- **INPATIENT F A C I L I T Y I** ----------	

30. Contacted facility name	
31. Facility contact information: (Name, Title, Telephone and Email Address)	
32. Facility response	
---------- INPATIENT F A C I L I T Y II ----------	
33. Contacted facility name	
34. Facility contact information: (Name, Title, Telephone and Email Address)	
35. Facility response	
----------INPATIENT F A C I L I T Y III ----------	
36. Contacted facility name	
37. Facility contact information: (Name, Title, Telephone and Email Address)	
38. Facility response	

Please save this form as a PDF attachment and submit it through the SECURE EMAIL PORTAL